Special Terms and Conditions

Title; Oregon Reform Demonstration
Number: 11-W-00046-0
Awardee: Oregon Department of Human Resources

1. The State must demonstrate to CMS that sufficient access and capacity are available to potential enrollees prior to outreach, marketing, and enrollment for Phases 1 and 2. This will include consideration of individuals who currently rely on Federally Qualified Health Centers and Rural Health Clinics. At a CMS site visit to be scheduled, the State shall present the results of its analyses demonstrating sufficient access and capacity. Outreach, marketing, and/or enrollment shall not be initiated prior to receiving written approval by the CMS project officer.

2. The State must demonstrate to CMS that its quality of care monitoring system will be sufficient to detect possible problems created upon the introduction of the Phase 2 populations and additions to chemical dependency and mental health services. Enrollment shall not be initiated prior to receiving written approval of the monitoring system from CMS.

   Specifically, the following activities must be completed before implementation:

   - Identification of discrete populations to be studied;
   - Number of individuals in samples and criteria for selection;
   - A workplan showing the specific measurement technique to be administered, the time of the initial administration, and the frequency of administration. At a minimum, include the following: medical chart review, surveys, analyses of encounter data, client grievances and disputes, and analyses of the seven types of contractor quality reports.

   To be approved, the quality monitoring system must be in place and ready to operate upon implementation of the expanded demonstration, and measurements of quality indicators must begin shortly after implementation.

3. The State must demonstrate to CMS that its management information systems can adequately support all Phases 1 and 2 systems' requirements and that its encounter data system can incorporate the populations and services.

4. Modified and new model contracts between the State and health plans must be approved by CMS prior to the start date of the delivery of services for Phases 1 and 2. Copies of subcontracts or individual provider agreements with managed care organizations shall be provided to CMS upon request.

5. The State shall submit to CMS for review and approval all outreach and marketing materials targeted for Medicare/Medicaid dually eligible individuals.

6. Any revision to the approved priority list (integrated and physical) of condition/treatment pairs, including the cut-off line for covered services, shall be submitted to CMS for review and approval.

7. Oregon will adopt policies that will ensure that before denying treatment for an unfunded condition for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual has a funded condition that would entitle the individual to treatment under the program. In the case of a condition/treatment pair that is not on the prioritized list of health services or an unfunded condition/treatment pair in association with a co-morbidity, where the expected outcome is comparable to that of a funded condition-treatment pair, providers will be instructed to provide the specified treatment. Oregon will provide, through a telephone information line and through the applicable appeals process under subpart E of 42 CFR Part 431, for expeditious resolution of questions raised by providers and beneficiaries in this regard.

8. The Stare shall define a minimum data sct (which at least includes inpatient and physician *services)* and require all providers to submit these data. The State must perform periodic review, including validation studies, in order to ensure compliance. The Srate shall have provisions in its contract with health plans to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. The Srate shall develop a workplan showing haw collection of plan encounter data will be implemented and monitored; the workplan shall also identify State resources that will be assigned to this effort. The workplan shall describe how the Stare will use the encounter data to monitor implementation of the project and f e d findings directly into program change on a timely basis. If *the* State fails to provide accurate and complete encounter data for any managed care plan. it will be responsible for providing (at 100 percent State cost) to the designated CMS evaluator data abstracted from medical records comparable to the data which would be available from encounter reporting requirements.

9. The State will submit *to* the Center for Medicaid and State Operations and the CMS Regional Office copies of all financial audits of participating health plans and quality assessment reviews of *these* plans

10. The State will submit quarterly progress reports, which *are* due 60 days after the *end* of each quarter. The report should include a discussion of activities occurring during that quarter that impacted the operation of the demonstration, such as changes in administration, outreach and enrollment efforts, client and provider education, changes in benefits, changes in the managed care delivery systems, monitoring and evaluation efforts, appeal and grievance processing, and encounter data collection and processing. The report should also include proposals for addressing *any* problems identified in the quarterly report.

Reports should also contain tabulations *of* categorized eligibility counts, enrollments in each type of managed *care* delivery system, and utilization of health services generated

from encounter data. Each report should also contain a table showing the status of encounter data collection by plan, including any penalties assessed for incomplete or incorrect reporting.

11. The State will submit annual reports covering the 12-month period from July through June.

12. The State's new eligibility rules under the demonstration will not adversely affect Medicaid eligibility of person who: (a) have been determined to be eligible for Medicaid prior to the start date of the demonstration; and (b) remain eligible as of the day immediately prior to the start date of the demonstration; but only to the extent that these persons continue to meet the Medicaid eligibility criteria in effect on the day immediately prior to the start date of the demonstration.

13. The CMS project officer or designee will be available for technical consultation at the convenience of the awardee within 5 working days of telephone calls and within 10 working days on progress reports and other written documents submitted.

14. The CMS may suspend or terminate any grant in whole or in part at any time before the date of expiration whenever it determines that the awardee has materially failed to comply with the terms of the grant. The CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date.

15. The awardee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The CMS project officer shall not direct the interpretation of the data used in preparing these documents and reports.

16. The awardee shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project, and that informed written consent of the individual must be obtained for any disclosure.

17. The CMS project officer shall be notified prior to formal presentation of any report or statistical or analytical material based on information obtained through this grant. Formal presentation includes papers, articles, professional publications, speeches, and testimony. In the course of this research, whenever the principal investigator determines that a significant new finding has been developed, he or she will immediately communicate it to the CMS project officer before formal dissemination to the general public.

The final report of the project may not be released or published without permission from the CMS project officer within the first 4 months following the receipt of the report by the CMS project officer. The final report will contain a disclaimer that the opinions expressed are those of the awardee and do not necessarily reflect the opinions of CMS.

18. Certain key personnel, as designated by *the* CMS project officer, are considered to be essential *to* the work being performed on specific activities. Prior to altering the levels of effort of any of the key personnel among *the* various activities for *this* project, or *to* diverting those individuals to other projects outside of the scope of this award, the awardee *shall* notify the CMS grants officer and *the* CMS project officer reasonably in advance and shall submit justification (including name and resume of proposed substitution) in sufficient detail to permit evaluation of the impact on tho project. No alteration or diversion of the levels of effort of the designated key personnel from the specified activities for this project shall be made by the awardee without the approval of thc CMS grants officer and the CMS project officer.

19. At any phase of *the* project, including at thc project's conclusion, the awardee, if so requested by the project officer, must submit to CMS analytic data file(s), with appropriate documentation, representing *the* data developed/used in end product analyses generated under the award The analytic file(s) may include primary data collected, acquired, or generated under the award and/or data furnished by CMS, The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the principal investigator and the CMS project offices. The negotiated format(s) could include both file(s) that would be limited to CMS internal use and file(s) that CMS could make available *to* the general public.

20. At any phase of the project, including at *the* project's conclusion, the awardee, if so requested by the project officer, must deliver to CMS any materials, systems, or other items developed, refined, or enhanced in the course afar under *the* award, The awardee agrees that CMS shell have royalty-free, nonexclusive, *and* irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal Government purposes.

21. The CMS reserves the right to withdraw waivers or costs nor otherwise matchable at *any* time if it determines that continuing the waivers would no longer be in the public interest. If a waiver or costs not otherwise matchable is withdrawn, CMS will be liable for only normal closeout costs. If the demonstration ends before the scheduled termination date, budget neutrality as defined below must be met during the period that the waivers were in effect.

22. During the last 6 months of the demonstration, no enrollment of individuals who would not be eligible under current law will bc permitted.

23. Oregon will implement modifications *to* the demonstration by submitting revisions to the original proposal. The State shall not submit amendments to the approved State plan relating to the new eligibles.

24. All requirements of the Medicaid program expressed in current or new law, regulation, and policy statement, not expressly waived or identified as not applicable in the award

letter of which these terms and conditions are part, shall apply to the demonstration. The State shall, within a reasonable period of time to be defined by the Secretary of the Department of Health and Human Services, confirm the demonstration to any national health care, welfare reforms, or Medicaid changes that may be enacted. If Congress enacts limits on Medicaid expenditure growth, then these limits will be used in place of the limits in the budget neutrality attachment, if the congressional limits are lower.

25. Within 60 days of the date of this letter, the State must submit a Medicaid demonstration eligibility oversight plan as pan of the ongoing MEQC pilot program. The plan shall be designed to retrospectively measure the accuracy of the eligibility process utilized by the State to assign and count both current and new eligibles by category.

26. The State shall provide quarterly expenditure reports (HCFA 64s) that provide expenditures on both the currently eligible and newly eligible populations under the demonstration. The CMS will provide Federal Financial Participation only for annual expenditures that do not exceed pre-defined limits on the number of demonstration eligibles and costs incurred, following the attached budget guidelines.

27. Oregon will be responsible for developing a detailed operational protocol describing &he section 1 I 15 demonstration. The protocol will serve as a stand-alone document that reflects the operating policies and administrative guidelines of the demonstration. The protocol will be submitted for approval no lata than 120 days after the extension period begins. Oregon shall assure and monitor compliance with the protocol-

ADDITIONAL TERMS AND CONDITIONS APPLIED TO WAIVER AMENDMENTS

28. FUNDING LINE MOVEMENT ON THE PRIORITY LIST

A. In the case of noncovered condition/treatment pairs, OMAP will direct providers to inform patients of appropriate treatments, whether funded or not, for a given condition, and will direct providers to write a prescription for treatment of the condition where clinically appropriate. OMAP will also direct providers to inform patients of future health indicators, which would warrant a repeat visit to the provider.

B. Oregon will clarify that pelvic pain conditions with abscesses, or active or ongoing bacterial infections, will be covered under condition/treatment lines #506, 308, and 288.

C. The OMAP will direct physicians to refer patients with upper and lower limb deformities (Lines #594 and 595) to health care providers willing to treat such patients without charge, where appropriate.

29. PREMIUMS

A. The State will (1) monitor disenrollments from the Oregon Health Plan due to nonpayment of premiums, and (2) monitor requests for waiver of premiums. This monitoring of premium waiver requests will include tracking: (1) the number of waiver requests received by type (i.e., zero income or the specific objective: criteria used as a basis for the request); (2) the number of requests approved and disapproved; and (3) the reasons for denial of the premium waiver requests. This information will be included in the quarterly report submitted by the State to CMS beginning with the quarter ending April 30, 2002.

B. Oregon will add new criteria for waiver of premiums if its analysis of denied waiver requests indicates a need for additional criteria for premium waivers. The State will notify CMS of any additional categories it adopts.

C. The State shall send samples of all premium notices, instructions for filing waivers, and any other public notices relating to imposition of premiums, disenrollment for non-payment of premiums, and beneficiary rights and responsibilities under the premium requirement to CMS for review.

30. ELIMINATION OF THE 30-DAY GRACE PERIOD FOR DISENROLLMENT WITHOUT CAUSE AND MAKING SELECTION OF A MANAGED CARE OPTION A CONDITION OF ELIGIBILITY FOR EXPANSION ELIGIBLES

A. Oregon will keep records of the number of requests by Oregon Health Plan participants for disenrollment from plans during their first 30 days of enrollment and the number of denials of such requests, and include this information in the State's Quarterly Reports to CMS.

B. In the State's Quarterly Reports, Oregon will also provide information on any problems that are identified in connection with the implementation of these new amendments. This information should include summaries of corrective actions taken by the State in response to the problems identified-

MONITORING BUDGET NEUTRALITY

Oregon will be at risk for the per capita costs provided in the proposal for both current and new eligibles, but not at risk for the number of current eligibles. By providing Federal Financial Participation (FFP) for all current eligibles, Oregon will not be at risk for changing economic conditions. However, by placing Oregon at risk for the per capita costs provided in the proposal for both current and new eligibles, CMS assures that the demonstration expenditures will reflect Oregon's estimates of savings from managed care, the priority list, and the employer mandate. Oregon will be at partial risk for the number of new eligibles by using the State's estimate of the ratio of new eligibles to current Aid to Families with Dependent Children (AFDC)-type eligibles to limit the number of new eligibles for which FFP will be provided.

For the purpose of determining budget neutrality for the demonstration, the trend rate for the 3-year extension period will be 8 percent for the Phase 1 and Phase 2 populations.

Budget neutrality will be determined over the 11 years of the demonstration. Any savings from budget neutrality accrued beneath the budget neutrality cap during the first 8 years of the demonstration may only be applied to an eligibility expansion or to offset costs of the existing demonstration in excess of the budget neutrality caps during the 11-year waiver period.

In the event the State would like to expand coverage during the 3-year extension period, the State must submit for CMS approval a waiver amendment requesting the expansion. In its amendment, the State must demonstrate that the eligibility expansion is sustainable, even when the accrued savings from the initial 8-year period are exhausted.

Nothing in this approval is intended to limit the ways in which budget neutrality will be calculated If this demonstration is extended for subsequent periods.

LIMITS ON FEDERAL EXPENDITURES

Eligibility Groups subject to Limit - The Oregon per capita cost estimate for the current eligible population and newly eligible populations will be the basis for establishing the limits of FFP.

Limit on Demonstration Expenditures-The annual limits are defined as follows:

a. Current Eligibles: ~cru dumber of current *eligibles* rimes the Oregon estimate of per capita cost for current eligibles.

b. New Eligibles: Actual number of current AFDC-type eligibles times the Oregon ratio of new eligibles to current eligibles times the Oregon estimate of per capita cost for new eligibles.

MONITORING SYSTEM

The form HCFA-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, will be used for monitoring Oregon expenditures under the demonstration.

Oregon will continue to submit a HCFA-64 for the entire Medicaid program. Total demonstration waivered expenditures will be included in the base form HCFA-64.9. In addition, Oregon will also submit three HCFA-64.9 forms that will list the waivered Medical Assistance Payments (MAP) expenditures and include the waiver type; i.e., section 1115 and section number on each form. The first form will report the waivered expenditures by *MAP* category for the current and new eligible. The second form will include waivered expenditures by MAP category for the current eligibles. The third form will include waivered expenditures by MAP *category* for the new eligibles. The actual eligibles associated with the expenditures reported on the first, second, and third forms will be detailed under each eligibility group; i.e., total, current, new, or on a narrative form.

The HCFA-64, including additional forms HCFA-64.9 and HCFA-64.10, will be used to monitor Oregon's expenditures under the demonstration. The FFP will be provided to the States for its actual expenditures, but limited to the caps.

Finally, the State will incorporate the budget estimates and number of eligibles into the Medicaid Budget Report, HCFA-37, for the applicable quarter end years requests. In addition, the State will prepare a narrative explanation form, which will list the amount of total and computable and Federal funds for the quarter and years requested far MAP and ADM expenditures.